PRINTED: 04/05/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED
AND PLAN	OF CORRECTION	15G593	A. BUILDING	01	03/13/2012
		100000	B. WING	ADDRESS, CITY, STATE, ZIP CODE	00/10/2012
NAME OF F	PROVIDER OR SUPPLIEF	R		2ND PL E	
REM-INC	DIANA INC			RT, IN 46342	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
K0000	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
KUUUU					
	A Doct Survey D	evisit (PSR) to the Life	K0000		
	1	ertification Survey			
	1	/17/12 was conducted by			
		Department of Health in			
		42 CFR 483.470(j).			
	accordance with	12 0110 103.170(j).			
	Survey Date: 03	3/13/12			
	Facility Number	: 001107			
	Provider Numbe	r: 15G593			
	AIM Number: 1	00245570			
	Surveyor: W. C.	hris Greeney, Life Safety			
	Code Specialist				
	At this Life Safe	•			
		c. was found not in			
	_	Requirements for			
	1 ^	Medicaid, 42 CFR			
	_	(j), Life Safety from Fire			
		tion of the National Fire			
		ciation (NFPA) 101, Life			
		C), Chapter 33, Existing			
	Residential Boar	d and Care Occupancies.			
	This one story fa	icility was fully			
	I	e facility has a fire alarm			
	_	oke detection in corridors,			
	1 -	and common living areas.			
		a capacity of 8 and had a			
	1	e time of this survey.			
		,			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

PRINTED: 04/05/2012 FORM APPROVED OMB NO. 0938-0391

	of correction identification number: 15G593	A. BUILDING B. WING	<u>01</u>	COMPLETED 03/13/2012
	PROVIDER OR SUPPLIER	3142 62	.ddress, city, state, zip code ND PL E T, IN 46342	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
	Calculation of the Evacuation Difficulty Score (E-Score) using NFPA 101A, Alternative Approaches to Life Safety, Chapter 6, rated the facility Prompt with an E-Score of 0.9. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 03/14/12. The facility was found not in compliance with the aforementioned requirements as evidenced by:			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: C8BH22

Facility ID: 001107

If continuation sheet Page 2 of 11

PRINTED: 04/05/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 15G593	A. BUII	LDING	01	COMPLI 03/13/2	ETED
		100000	B. WIN			00/10/	2012
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
REM-IND	IANA INC				2ND PL E RT, IN 46342		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		ID	AD CAMPANIA MANAGE CONTROLLA		(X5)
PREFIX	(EACH DEFICIENC	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG				TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	DATE
	REGULATORY OR 483.470(j)(1)(i) LIFE SAFETY COPROMPT Where an autominstalled, for either coverage, the system in a The adequacy of documented to the jurisdiction. Exception No. 1: facilities, an automatic accordance with Installation of Spectro Family Dwell Homes, is permit not required in olft. and in bathrooprovided that such lath and plaster of minute thermal be the Exception No. 2: Exception No. 2: Exception No. 3: evacuation capal automatic sprinkled with NFPA 13, Signinkler System not required in olft and in bathrooms provided that such and plaster of the provided that such and in bathrooms provided that such and plaster of the provided that such and plaster	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) ODE STANDARD atic sprinkler system is er total or partial building stem is in accordance with .3.5.2 and activates the fire accordance with 33.2.3.4.1. If the water supply is ne authority having In prompt evacuation matic sprinkler system in NFPA 13D, Standard for the rinkler Systems in One and ings and Manufactured ted. Automatic sprinklers are osets not exceeding 24 sq. ims not exceeding 55 sq. ft., ch spaces are finished with or materials providing a 15 arrier. Not applicable In prompt and slow boility facilities where an interest and system is in accordance tandard for the Installation of its, automatic sprinklers are osets not exceeding 24 sq. ft is not exceeding 55 sq. ft., ch spaces are finished with or material providing a 15 arrier. In prompt and slow boility facilities up to and wries in height, systems in			CROSS-REFERENCED TO THE APPROPRIAT	TE .	
		NFPA 13R, Standard for the rinkler Systems in					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: C8BH22

Facility ID: 001107

If continuation sheet Page 3 of 11

PRINTED: 04/05/2012 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPLE CO LDING	NSTRUCTION 01		LETED
		15G593	B. WIN	IG		03/13	/2012
	ROVIDER OR SUPPLIER		•	3142 62	ddress, city, state, zip coe ND PL E T, IN 46342	DE _	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFRENCED TO THE APP DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
		upancies up to and Including leight, are permitted.					
	Exception No. 5:	Not applicable					
	system is not red	Initiation of the fire alarm quired for existing ccordance with 33.2.3.5.5.					
	installed, for eith coverage, the sy Section 9.7 and system in accordadequacy of the	ratic sprinkler system is er total or partial building stem is in accordance with activates the fire alarm dance with 33.2.3.4.1. The water supply is documented having jurisdiction.					
	Exception No. 1:	Not Applicable					
	Exception No. 2:	Not Applicable					
	evacuation capa automatic sprink with NFPA 13, S Sprinkler System not required in c ft. and in bathroo provided that suc	In prompt and slow bility facilities where an ler system is in accordance tandard for the Installation of ins, automatic sprinklers are losets not exceeding 24 sq. oms not exceeding 55 sq. ft., ich spaces are finished with or material providing a 15 parrier.					
	evacuation capa including four sto accordance with Installation of Sp Residential Occu Four Stories in F	In prompt and slow bility facilities up to and bries in height, systems in NFPA 13R, Standard for the brinkler Systems in upancies up to and Including deight, are permitted.					
	Exception No. 5:	NOT Applicable					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: C8BH22

Facility ID: 001107

If continuation sheet

Page 4 of 11

PRINTED: 04/05/2012 FORM APPROVED OMB NO. 0938-0391

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE S			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	DDIG	01	COMPLETED	
		15G593	A. BUII B. WIN			03/13/2012	
			B. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIEF	₹					
	MANIA INIC				ND PL E		
KEW-IND	REM-INDIANA INC			ПОВАК	RT, IN 46342		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
TAG	Exception No. 6. system is not recinstallations in a IMPRACTICAL Where an autominstalled, for eith coverage, the system in accordadequacy of the to the authority has exception No. 1. Exception No. 1. Exception No. 2. evacuation capa sprinkler system 13D, Standard for Systems in One and Manufacture water supply, is and closets are sprinklers are not exceeding 55 sq spaces are finish materials providibarrier. Exception No. 3. Exception No. 4. Exception No. 5. capability facilities stories in height, NFPA 13R, Star Sprinkler System	cordance with 33.2.3.5.5. Inatic sprinkler system is per total or partial building system is in accordance with activates the fire alarm dance with 33.2.3.4.1. The water supply is documented naving jurisdiction. 33.2.3.5.2. In slow and impractical ability facilities, an automatic in accordance with NFPA or the Installation of Sprinkler and Two Family Dwellings and Homes, with a 30 minute permitted. All habitable areas sprinklered. Automatic of required in bathrooms not permitted in the provided that such need with lath and plaster or ing a 15 minute thermal		TAG	DEFICIENCY)		DATE
		ermitted. All habitable areas sprinklered. Automatic					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: C8BH22

Facility ID: 001107

If continuation sheet Page 5 of 11

PRINTED: 04/05/2012 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G593	A. BUI	LDING	01	(X3) DATE : COMPL 03/13/	ETED
NAME OF P	PROVIDER OR SUPPLIER		B. WIN	STREET A	ADDRESS, CITY, STATE, ZIP CODE	03/13/	2012
REM-IND	DIANA INC				2ND PL E RT, IN 46342		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
TAG	sprinklers are no exceeding 55 sq spaces are finish materials providi barrier. Exception No. 6: system is not recinstallations in ad Based on observate facility failed to 9 rooms and 1 of paint. LSC 32.2: section 9.7. LSC 25, the Standard Testing, and Mai Fire Protection S 2-2.1.1 requires a corrosion, foreig Any sprinkler shapainted, corroded This deficient practicents in the livic kitchen or hallwar room and kitcher Findings include Based on observation and 12:20 pm on facility Program was noted: two on living room, two combined kitcher	Interest in bathrooms not a ft., provided that such and with lath and plaster or any a 15 minute thermal. Initiation of the fire alarm quired for existing accordance with 33.2.3.5.5. The ation and interview, the ensure sprinklers in 3 of a fall hallways were free of a fire storage of the Inspection, and interest in the Inspection in the In	KSO		The vendor has been contact to replace or clean the sprinkl throughout the home that wer observed to have paint on the specifically including 1 in the living room and 1 in the family room. In addition the sprinkler that were observed to have do on them will be cleaned specifically including 1 in the kitchen, 1 in the family toom a 2 in the hallway between the kitchen and family room. In the future, the Home Manager will monthly walk throughs of the home to ensure that sprinkler are free from paint or other de that could interfere with their functioning properly. If it is no that the sprinklers need clean or replaced, the Home manage will notify the Program Direct contact the vendor. Responsit Party: Area Director Completic Date: 4/12/2012	ed ers e em, rs rt and e I do s ebris ted ed er rt or to ole	03/28/2012

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: C8BH22

Facility ID: 001107

If continuation sheet

Page 6 of 11

PRINTED: 04/05/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION IDENTIFICATION NUMBER: 15G593	A. BUILDING B. WING	01 	COMPLETED 03/13/2012
	PROVIDER OR SUPPLIER	3142 62N	DDRESS, CITY, STATE, ZIP CODE ND PL E 7, IN 46342	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
TAG	one sprinklers in the bedroom hallway had paint on the deflectors which matched the color of the ceiling paint. This was acknowledged by the Program Director at the time of the observations. This deficiency was cited on 02/17/12. The facility failed to implement a systemic plan of correction to prevent recurrence.	TAG	DEFICIENCY)	DATE

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: C8BH22

Facility ID: 001107

If continuation sheet Page 7 of 11

PRINTED: 04/05/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 15G593	A. BUII B. WIN	DING	01 	COMPLETED 03/13/2012	
			b. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER				2ND PL E		
	DIANA INC				RT, IN 46342		
(X4) ID		TATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	•	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG KS154		LSC IDENTIFYING INFORMATION)		TAG	DETERMET)		DATE
K0104		ODE STANDARD d automatic sprinkler system					
	·	for more than 4 hours in a					
	24-hour period, tl	he authority having					
		be notified, and the building					
		ed or an approved fire watch					
		led for all parties left ne shutdown until the					
		has been returned to					
	service. 9.7.6.						
	Based on record	review and interview, the	KS1	54	The facility has a policy in place		03/28/2012
	facility's written	policy failed to contain			that contains procedures to fol in the event that the automatic		
	complete proced	lures to be followed in			sprinkler system or fire system		
	the event the auto	omatic sprinkler system			out of service for more than 4		
	has to be placed	out of service for 4 hours			hours in a 24 hour period.The		
	or more in a 24 h	our period to protect 7 of			policy has been updated to		
	7 clients. LSC 33	3.7.1 requires plans for			include that the survey agency contacted when the sprinkler	ре	
	the protection of	residents shall include			system is down for 4 or more		
	special staff resp	onse, including the fire			hours. In addition, the policy		
	protection proced	dures needed to ensure			includes that staff will complete	e a	
	the safety of any	resident. This deficient			through of the home every 15 minutes which will be		
	practice could aft	fect all occupants.			documented.All staff will be		
	Findings include:	:		trained on the updated policy and the documentation page will be in place at the home. The Indiana Mentor Procedures for a Fire		e in	
	During review of	f the facility's undated			Watch policy will be reviewed	with	
	"Procedures for a	a Fire Watch" on			staff upon hire and every quar		
	03/13/12 at 11:50	am with the Program			thereafter.Responsible Party:		
	Director, the prod	cedures stated "staff on			Area Director Completion Date 4/12/2012	e:	
	duty to complete	a walk through of the			7/12/2012		
	home to include t	the basement and the					
	garage every two	hours." The procedures					
		icate the survey agency					
		en the sprinkler system					
		ore than four hours. The					
							l l

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: C8BH22

Facility ID: 001107

If continuation sheet Page 8 of 11

PRINTED: 04/05/2012 FORM APPROVED OMB NO. 0938-0391

	of Correction identification number: 15G593	A. BUILDING	01	COMPLETED 03/13/2012
	PROVIDER OR SUPPLIER	3142 62	ADDRESS, CITY, STATE, ZIP CODE	
	DIANA INC	HOBAR		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE COMPLETION
	Program Director indicated direct care staff on duty and assigned to the supervision of residents were responsible to complete the walk through and documentation every two hours. Therefore, it cold not be assured the facility had a system that would alert staff and residents in sufficient time in the event of a fire occurring when the sprinkler system was down. This deficiency was cited on 02/17/12. The facility failed to implement a systemic plan of correction to prevent recurrence.			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: C8BH22

Facility ID: 001107

If continuation sheet

Page 9 of 11

PRINTED: 04/05/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	01	COMPL	
		15G593	B. WIN	G		03/13/	2012
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
DEMINIS	NANIA INIO				2ND PL E		
REM-INL	DIANA INC			HOBAR	RT, IN 46342		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX	·	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
KS155	483.470(j)(1)(i) LIFE SAFETY County Where a required service for more period, the author be notified, and the evacuated or an watch shall be produpted by the alarm system has 9.6.1.8 Based on record facility's written complete procedute event the Fire placed out of service in a 24 hour periodients. LSC 33. protection of resist special staff respecial staff respective staff respect	ODE STANDARD If fire alarm system is out of than 4 hours in a 24-hour ority having jurisdiction shall the building shall be approved fire rovided for all parties left the shutdown until the fire is been returned to service. The review and interview, the policy failed to contain flures to be followed in the Alarm system has to be evice for 4 hours or more and to protect 7 of 7. The requires plans for the idents shall include the onse, including the fire flures needed to ensure resident. This deficient fect all occupants. If the facility's undated the fire watch on the idents shall include the same with the Program cedures stated "staff on a walk through of the the basement and the original the sprinkler system."	KS		The facility has a policy in place that contains procedures to for in the event that the automatic sprinkler system or fire system out of service for more than 4 hours in a 24 hour period. The policy has been updated to include that the survey agency contacted when the sprinkler system is down for 4 hours or more. In addition, the policy includes that staff will complet walk through of the home even 15 minutes which will be documented. All staff will be trained on the updated policy the documentation page will p in the home. The Indiana Men Procedures for a Fire Watch policy will be reviewed with staupon hire and every quarter thereafter. Responsible Party: Area DirectorCompletion Date 4/12/2012	Illow this this this the this the this the this this this this this this this this	03/28/2012
	was down for mo	ore than four hours. The					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: C8BH22

Facility ID: 001107

If continuation sheet

Page 10 of 11

PRINTED: 04/05/2012 FORM APPROVED OMB NO. 0938-0391

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G593	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	COM	E SURVEY PLETED 3/2012
	PROVIDER OR SUPPLIEF		3142 6	ADDRESS, CITY, STATE, ZIP 2ND PL E RT, IN 46342	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	staff on duty and supervision of reto complete the documentation e Therefore, it color facility had a system and residents in event of a fire of Alarm system where the facility failed the facility failed the supervision of the facility failed to the supervision of the facility failed to complete the supervision of the facility failed to complete the supervision of the sup	esidents were responsible walk through and very two hours. If not be assured the stem that would alert staff sufficient time in the eccurring when the Fire				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: C8BH22

Facility ID: 001107

If continuation sheet Page 11 of 11